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# Medical Care

## Leadership Supplied by a Medical Association

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IT HAS LONG BEEN AGREED that our great profession best serves the public when it is free, unfettered and unregimented.

First as your president-elect and then your president, I have just completed a two-year tour of duty in support of the principles of *medical freedom*—two years that have been the most gratifying, most rewarding in my entire medical career.

During this period I have met with the officers and members of every one of our 40 component county societies and have learned anew that, regardless of geography in our great commonwealth, you find high standards of medical care. And, you find men and women eager to cooperate in the solution of our mutual problems.

If I were called upon for a definition of our organization in a single sentence, I think I might say:

"On the professional side as well as on the newer front of medical economics, the California Medical Association is a proven progressive organization devoted to the welfare of the citizens of our state."

Our many activities substantiate the definition. Our accomplishments give it real meaning.

For example:

Our Blood Bank Commission, after years of struggle and sacrifice, has been instrumental in establishing a chain of professionally-managed blood banks which serve most of California. This accomplishment has taken intelligent medical direction plus money—your money. Californians today would not have the medical security that these banks afford had not the profession advanced many thousands of dollars of credit to provide the necessary physical facilities throughout the state.

Your Cancer Commission continues its search for a cure of this dread disease on the one hand while standing guard over the public's health in its daring to expose quackery on the other.

The Committee on Scientific Work and the Committee on Postgraduate Activities have completed a highly successful year in helping all of us keep stride with the advances of modern medicine.

Your Committee on Public Policy and Legislation has served both the profession and the public in furthering measures in the interest of sound health policies and opposing those schemes—no matter how high-sounding the titles—which are unsound and endanger us all.

The Medical Services Commission has spent countless hours in exploring all types of medical care plans. The committee members, in their service to the profession, have met with leaders in management and labor; insurance and hospital executives and others.

In answer to a growing need, leaders of your profession have participated in such self-explanatory conferences as "Physicians and Schools" and "Rural Health."

Address of the President: Presented before the First Meeting of the House of Delegates at the 84th Annual Session of the California Medical Association, San Francisco, May 1-4, 1955.

Results have been most fruitful if for no other reason than, by our actions, we have shown our willingness to discuss mutual medical problems and projects with equally sincere groups.

Activity generated at the state level is already reaping benefits at the action level—the community level.

A public that is aware of our professional dedication to health protection cannot but respect our sincerity and our integrity as we approach the problems revolving around medical economics—medical care insurance.

To me, health insurance has always meant that a group of people contract to pay agreed shares into a common fund.

Money is then taken out of the fund in specified amounts to take care of the illnesses or accidents which may befall the unfortunate.

The fortunate members, strictly speaking, are those who were not incapacitated by unpredictable sickness or accident.

We insure against the unpredictable.

So-called "comprehensive coverage" does not fall in the realm of the unpredictable. It covers everything. Comprehensive coverage is bookkeeping and not insurance. It means simply that *all the members* in a given group, by contract, propose to pay *all the costs*—all the medical care bills of all the members, plus brokerage charges.

Currently in many segments of our society we find a dual clamor in regard to medical care. One is for "comprehensive coverage" and the other, tritely phrased, is for care "at a cost the subscriber to the plan can afford to pay."

It is my opinion, after many years' experience in C.M.A. and California Physicians' Service affairs, that if high medical standards are to be maintained; if the cost is to be reasonable, the profession and leaders in the insurance industry must place renewed emphasis in the education of purchasers of medical care to explain that *you simply cannot* have both.

To try to wrap up "comprehensive" and "low cost" in one package will mean that the string you use to tie it together will be labeled "mediocre medicine."

In the field of "things to be done in the future," I believe we should take the lead in offering a workable deductible plan of medical care coverage that puts the insurance emphasis on the catastrophic—*real coverage* when there is a *real need*—and deemphasizes the minor ailments encompassed in the "comprehensive" philosophy.

Once we produce a clearly understood explanation of the actual savings a family would make through the purchase of protection of a deductible plan; once we have a large number of subscribers covered by such a plan, then indeed, I believe, we will have attained the goal of low cost coverage and we will not have jeopardized medical care standards.

It was not such high sounding phrases as "economic forces," but only simple arithmetic that brought about our acceptance of deductible automobile insurance. It is my prediction that common sense will bring the same eventual product for medical care insurance.

So much for the future. We are faced with more immediate problems—decisions to be made as to the course C.P.S. shall take.

Before going further on C.P.S., let me make a few observations regarding panel practice.

Legally, panel practice is here to stay. It cannot be attacked on that score. Legislatively, I believe the only approach should be to make certain that, in the interest of public protection, the panel practitioners deliver the services they promise the public —and deliver them 24 hours a day. When this is not done, we've already found, all of us are blamed.

Medically, panels will remain with us until we develop a more desirable product. Generally speaking, I believe we have the product. It is the tool every physician has—the tool he uses every day in seeing every patient. That tool is not the care *of* the patient, for that probably can be delivered through corporation medicine. The real tool is caring *for* the patient. Only the personal physician—surely not a corporation—can deliver that type of medical service.

Meanwhile, if we are to practice our profession as we have in the past, it is obvious that we must stress the value of the concept of *caring for the patient* by the personal physician.

And that, in the light of the growing number of families availing themselves of prepaid medical care through group enrollments, can best be accomplished by providing California Physicians' Service with competitive contracts.

As facts and other data have been gathered and assembled for use in recommending a continuous program in the development and growth of C.P.S.-Blue Shield, it has become increasingly apparent that it is necessary to specifically define growth objectives.

C.P.S.-Blue Shield has now passed through the stages of infancy and adolescence, where decisions and policies were made from day to day and actions taken in terms of the immediately expedient. It is now into the stage of maturity, where further growth and development should follow a plotted course to a planned result in so far as this is possible in a time of rapid social and economic changes.

Most phases of C.P.S. operation, including the groups to be covered, the types of contracts needed to attract these groups, the size of the C.P.S. organization, the character of its leadership, the future utilization of electronic record-keeping equipment,

the size and location of housing facility, and practically every phase of C.P.S. operation requiring management decision and direction, is dependent upon the number of subscriber members to be served.

We have now reached a point where some of our earlier abstract opinions and theories on health insurance can be replaced by facts developed through experience and research.

First, there is much to encourage us. We know now that we have the tools and the ability with which to preserve freedom for doctors and patients in the face of closed panel competition. Our approach can be positive; it can be constructive.

The good physician-patient relationship, plus a service plan, are the principal tools needed to compete for the favorable decision of the buyer of health insurance. We have those tools. Many of our county societies and their members are already using them, and with excellent results.

Needed also are the positive public service programs of the county medical societies as prescribed by the C.M.A. Public Relations Department—24-hour emergency service for the community, health information service, medical care for all regardless of ability to pay, community leadership, protection of patients from excessive fees, from malpractice, from unnecessary procedures and from incompetence.

It is my responsibility, as your retiring president, to urge you not to lose by default the continuing battle for the control of medicine. We must keep C.P.S. strong and effective, for if we want to maintain any influence or control over health insurance, we must control a health insurance plan that can sell competitively, that can satisfy the desires of the purchasers of health insurance.

Our plan, C.P.S., with a $4,200 income ceiling, cannot compete successfully for large groups. It has only two or three large groups in the entire state. But in those areas where the doctors have asked that the ceiling be raised to $6,000, C.P.S. has been successful in competition with the closed-panel plans. The $6,000 income ceiling satisfies the desires of the purchasers of health insurance.

If we do not have an effective instrument in the health insurance field, the control will go to others, to the insurance industry, to the labor leaders, to the state, or to the closed panel plans.

Insurance industry control of medical economics is familiar to you. You need only review our years of struggle to get even minimal increases in the Workmen's Compensation schedule. We don't want that for all of medicine. Nonprofessionals, no matter how well intentioned, must not be permitted to seize the control through our inaction.

C.P.S. was founded by the doctors of California through this House of Delegates in 1939. Its purpose was and is to provide service to the public. It has successfully combated the attempts of two governors to socialize medicine in this state. And now, again, wherever it is brought up-to-date and armed with a $6,000 income ceiling, it is proving its effectiveness against schemes aimed at taking over control of medicine and the patient. C.P.S. is not only *our* plan. It is our only hope in the immediate future. I urge you to make it strong, and to keep it strong.

This does not mean that, overnight, C.P.S. is to double and treble its size. It does mean, however, that continued and steady growth will set a competitive pattern for other plans to follow to the end that the public will be even better served be the plans service or indemnity.

Speaking most objectively, and in no way reflecting on the sales and promotional efforts of C.P.S., I think it is a fair statement that membership has not even kept pace with our population growth. It therefore seems logical to base a projection of C.P.S.-Blue Shield growth goals on the present market position of the organization. Nationally the 77 professionally-controlled Blue Shield plans cover 19.06 per cent of the population, as compared with C.P.S. coverage of 5 per cent plus of the California population.

To compare the figures in California with those of the 77 National Blue Shield plans requires that the membership in both Blue Cross plans in California be considered, inasmuch as the majority of the other larger Blue Shield plans operate jointly with Blue Cross.

If the membership of the two Blue Cross plans in California is added to the membership of C.P.S.-Blue Shield, the proportion of population covered is approximately 15 per cent. From the California State Chamber of Commerce Survey of Voluntary Health Insurance in California, adjusted to current population figures (12,500,000) augmented by June 30, 1954, reports of Blue Cross, and a conservative estimate of Kaiser, Ross-Loos and other groups, the following is the approximate number of people covered by some form of health and accident insurance:

| | Persons Covered | Per Cent Population |
|---|---|---|
| Commercial insurance companies | 2,613,000 | 20.1 |
| C.P.S.-Blue Shield (Jan. 31, 1955) | 681,551 | 5.5 |
| Blue Cross-Oakland (June 30, 1954) | 599,885 | 4.7 |
| Blue Cross-Los Angeles (June 30, 1954) | 582,368 | 4.6 |
| Kaiser Health Foundation | 450,000 | 3.6 |
| Ross-Loos | 100,000 | .8 |
| Railroad self-insured | 80,000 | .64 |
| Industrial self-insured | 54,000 | .43 |
| Students—University health plans | 45,000 | .36 |

The preponderance of the population covered by agencies beyond the control of the medical profession is worthy of note. The tangible evidence of the attitude of insurance companies toward the medical

profession is illustrated by these companies over a period of years in the field of industrial medicine.

Recently there have been developed Labor-Management committees sponsored by commercial carriers, which are evaluating both the ethical propriety and the dollar value of professional services before claims of policyholders are approved and paid.

In certain areas of the state, physicians have been asked to "accept" commercial indemnities as full payment for services rendered. This development has been aggressively promoted by several of the larger insurance companies, and has been repeatedly requested by representatives of the group of organized insurance companies operating in this field.

The medical profession does not control the operating policies or the market practices of the commercial insurance companies, and it certainly is not likely to do so. Insurance is a business, not a professional service, and it is the business practice of hanging an indemnity price tag on professional services that has had much to do with the growing public opinion that professional fees, if they exceed the indemnity allowance, are excessive. And perhaps more significantly in the long run, that professional services are a market commodity.

Nevertheless, it should be noted that commercial carriers, practically inactive a few years ago in the medical insurance field, are stepping up their promotional operations. Nationally the insurance companies cover approximately 34 per cent of the persons who have some form of health and accident insurance, whereas in California the private insurance companies cover approximately 50 per cent.

The benefits of the policies offered by these insurance companies are being broadened. Financial relationships with industry and labor are being exploited, and premiums are being lowered for volume sales. In short, the insurance industry is committed to a policy of saturation expansion within the framework of capital return.

Private insurance companies have the special advantage of an existing grass roots California sales organization of approximately 9,000 licensed agents and brokers to distribute their policies, according to data from the Department of Insurance of California. It now controls the coverage, in medical claims payments, for a group equal to 20 per cent of the California population, and controls more than 50 per cent of the medical care insurance of all types now in force within the state.

The competitive position of C.P.S.-Blue Shield as it relates to closed panel groups (especially the Kaiser Health Foundation) is largely dependent upon the funds available for the expansion of facilities.

During the past few years the number of clinics in various sections of the state, but especially in Southern California, has been on the increase. Some of these clinics are now offering medical care to such persons as can practically use the clinics, for fees comparable to the dues paid by subscriber members of C.P.S.

Where these clinics have been well organized—and relatively large numbers of people live within easy traveling distance to the clinics—they have been quite successful in enrolling an increasingly large number of people. There is every evidence that the growth of the number of clinics will accelerate and these clinics might become a competitive factor, especially in the field of the sale of individual contracts.

The growth of the larger closed panel plans has been slowed down, due to the lack of funds for the building of clinics and hospitals. Should additional Federal money become available, then the large closed panel plans will become an even greater factor in this competitive market.

Competitively, then, how large should C.P.S.-Blue Shield be to maintain its position in this medical care field?

In chatting informally with one physician on this subject, we agreed that:

"C.P.S. should be large enough to constructively influence all health and accident insurance and voluntary plans—both closed and open panel—but not so large as to be a monopoly or to have any appearance of domination, in order that the individuals covered by any prepaid plan or health insurance may be best served."

Obviously the projection of growth goals for C.P.S. in the California market can be no more than the setting of bench marks attainable under anticipated circumstances, and subject to revision and adjustment when and if circumstances change.

Your decision on a growth objective that will hold for a period of possibly five years will be most helpful in reaching the many management decisions necessary in future planning.

A decision as to this growth objective, too, will be extremely beneficial in guiding the course of C.P.S. relations with physicians—in cooperating with county societies and the C.M.A.—and will certainly have a material influence on both C.P.S. public relations and sales policies.

On an entirely different front, boards of supervisors, taxpayers' groups and others, I believe, should be interested in using the vehicle of prepaid medical care insurance for the continued home town care of veterans, care of military dependents and care of indigent persons.

Following World War I, and again in the ten years since World War II, the bureaucratic ambi-

tions of the Veterans Administration have increased the number of hospital beds to 117,580.

You will perhaps recall that the first report of the Hoover Commission was quite critical of the expansion of the vast facility of the Veterans Administration, and there has been some effort made to curb the growth and extension of hospital facilities.

Through this expansion period the Veterans Home Town Care Program was developed and, as is of course generally known, is more extensive in California than elsewhere.

Many of the Blue Shield plans made some effort to develop a Home Town Care Program, but only California, Michigan and North Carolina have really been a factor in preserving for the private practice of medicine a portion of this service to veterans. In California, where many veterans are located many miles from any veteran facility, the rendering of better service to these veterans has been not only possible, but very evident.

The administration is still continuing its program of eliminating as many Home Town Care programs handled by organizations such as Blue Shield as possible. In some states contracts that were not acceptable were presented, and thus the programs have been discontinued.

Recently such a contract was submitted to C.P.S., and negotiations are now being carried on to revive the previous contract with amendments and changes to fit conditions.

The case load of veterans handled through C.P.S. runs approximately the same, at 12,000. The annual expenditure by the government for these veterans under the Home Town Care Plan has, however, continuously decreased, until the amount spent in 1954 was $1,506,951.

It will probably be extremely difficult for California to maintain its position without a change in trend throughout the nation, and if such a renewed program on a nationwide basis is not undertaken, it is believed that it is only a question of time until the Veterans Home Town Care Program in California will be eliminated.

It is suggested that we appoint a new Veterans' Committee, to be composed of at least four physicians who are active in the American Legion, three physicians who have a substantial number of veteran patients, and one representative of the C.P.S. trustees, plus such other physicians as might be interested and helpful.

During the past several years, physicians in various sections of the state have indicated interest in the development of an indigent program that might better serve indigents and permit private physicians to serve those needing outpatient care in their own offices.

The indigent population in California as of November 30, 1954, was 485,402.

The population growth, accompanied by an increase in the number of indigents, is presenting a perplexing financial problem to many of the counties in the state, and we have heard, both directly and indirectly, from areas in which those most concerned are seeking a new and perhaps less costly method of rendering medical care to these indigents.

Some years ago C.P.S. took definite steps toward the development of an indigent program. At that time most of the physicians of the state were carrying such a load that only a few were aggressively interested.

At that time it seemed impossible to develop a program where costs could be determined, and interest in the suggested plans waned.

During the past five years, the Washington Physicians' Service has developed an indigent program which seemingly is satisfactory to the patient, the state, the physicians and, therefore, to W.P.S. The statistical and actuarial data gathered during this period could be of great help to C.P.S., should it be decided to aggressively enter this field.

It has been suggested that one or more of the state and county taxpayers' associations would gladly undertake the study of this problem from the economics side, provided funds were available to pay for direct costs. In those counties where the tax associations are most active, and do have an influence on the way the taxpayers' money is spent, it is believed that this might be a satisfactory approach.

Certainly a committee of physicians from the county society could well study the needs of the indigent from the service standpoint, with the hope that any plan developed would be substantially more helpful, psychologically and medically, than is possible under present conditions.

The projects that I have outlined, of course, are for the purpose of arousing intelligent discussion and not to raise fear that the problems are insurmountable. They are for the physicians of today and for the physicians of tomorrow.

Indeed, we are doing something about that too, as we have just completed two Student A.M.A. Public Relations Conferences, one in San Francisco and one in Los Angeles, for the physicians who are to take our places, where we have attempted to point up the value of protecting the private practice of medicine.

In summary, what I have been saying is this: When there is a medical problem, first, let us recognize it; second, let us study it carefully; third, let us then assert positive medical leadership to solve the problem in a manner which is equitable to the public, our patients and the medical profession.

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